reviews

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Handbook of Women's Health: An Evidence-Based Approach

Ed Jo Ann Rosenfeld

Cambridge University Press, £47.50, pp 613
ISBN 0 521 78833 1

Rating: ★★

The term "women's health" is best used to describe an approach to the care of a woman by her health providers rather than to denote a specialty. Editor Jo Ann Rosenfeld sets out to consider "the woman and her health needs in her position in her life cycle, her family, and society."

Her book is well organised and has sections on preventive care, sexuality, genitourinary medicine, breast disorders, psychological disorders, and common medical problems. Eating disorders, breast conditions, urinary incontinence, female cancers, and depression and premenstrual syndrome get special emphasis. There are separate chapters on lifestyle issues such as smoking and exercise. Of particular value are the chapters on issues with lesbian patients, woman battering, and breast disorders.

However, although this is a comprehensive text on women's health, it is neither useful as a handbook (being too large to carry) nor does it take the current evidence based approach. Its authors refer predominantly to organisational publications, position statements, and reviews for specific recommendations, often neglecting to identify the original or landmark studies. They rarely give the levels of evidence for making clinical recommendations or grade their recommendations. Also, there is little evaluation of the quality of the studies that they reference.

There are notable exceptions, however: the chapter on breast cancer screening evaluates the evidence and grades some of its recommendations, and the chapter on lesbian patients includes excellent clinical recommendations and approaches with a clear reference to the lack of quantity and quality of much of the data and the need to depend upon "best knowledge."

This book points out the societal as well as the biological differences between men and women. As such it makes a welcome addition to the office library of any doctor interested in women's health. I recommend it as a well referenced text rather than as an evidence based handbook.

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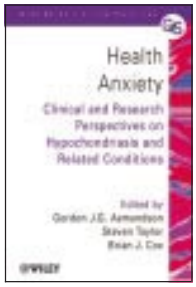
Health Anxiety: Clinical and Research Perspectives on Hypochondriasis and Related Conditions

Eds Gordon J G Asmundson, Steven Taylor, Brian J Cox



Wiley, £27.50, pp 415
ISBN 0 471 49104 7

Rating: ★★

Fear of serious illness is responsible for a high proportion of consultations with doctors. In most cases there is no confirmation of a serious cause and most patients can be easily reassured. Others continue to worry, to experience symptoms, and to limit their lives. Such persistent health anxiety is often difficult to treat and can be made worse by inconsistencies and ambiguities in medical care and by the lack of an acceptable explanation. While "unexplained" symptoms are often seen as an inappropriate use of health care, they are in fact genuine, often disabling, medical problems. They deserve to be taken seriously rather than abandoned to alternative medicine. Better and more informed care would result in better outcomes and would cut the heavy cost of treatment that is often ineffective and may reinforce disability.

There is now encouraging evidence about how to minimise and treat health anxiety; unfortunately it mostly relates to highly specialised treatments by a small number of clinical psychologists and psychiatrists working largely in specialised settings. There has been rather little progress in improving treatment in primary care and outpatient clinics.

The continuing lack of understanding within medicine is reflected in confused lay beliefs and an increasing number of controversial alleged syndromes. These conceptual difficulties are evident in the subtitle of the book, which refers to the historically old and controversial term hypochondriasis. Our Western separation of body and mind has made understanding of aetiology and treatment remarkably difficult. It results in medical specialties continuing to look for occult physical causes for symptoms with arbitrary descriptive names such as irritable bowel, chronic headache, and fibromyalgia, whereas psychiatrists use terms such as hypochondriasis, medically unexplained symptoms, and somatisation. However, patients find psychological causation unacceptable. A major reason why they are unhappy about their treatment is that their doctors are similarly bewildered.

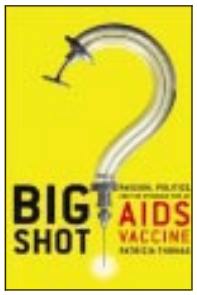
There is a need to stand back and look at the whole problem of symptoms without obvious pathology—what might best be referred to as *functional symptoms* and *functional syndromes*. While some will turn out to arise from major physical pathology, the majority are likely to result from how individuals perceive and interpret minor pathology or abnormal physiological processes—symptoms cannot be seen as "body" or "mind" but as an interaction of both. An understanding of this interactive aetiology has clear implications for treatment.

Health anxiety is an important clinical topic, which is beginning to attract greater medical attention. It deserves wide discussion within medicine as a basis for greatly improved medical care and also for a wider public understanding of the ever increasing list of controversial syndromes. Unfortunately, this book, intended for a wide readership, is considerably dominated by difficult and, for most potential readers, arcane arguments about psychiatric classification and specialist experience. However, it does bring together a number of general chapters on aetiology and treatment which, even if not radically new, are not as well known as they deserve to be.

Richard Mayou *professor of psychiatry, University of Oxford*

Big Shot: Passion, Politics, and the Struggle for an AIDS Vaccine

Patricia Thomas



Public Affairs, £19.99, pp 515
ISBN 1 891620 88 6

Rating: ★★★★

Every day more than 10 000 people around the globe become infected with HIV—two to three times the number who perished in the terrorist attacks of September 11. Day in and day out, the widening circle of AIDS quietly expands.

In the 20 years since AIDS was first recognised, more than 25 million people have died from complications of HIV infection. Another 40 million are today living with HIV, most with no hope of accessing costly new antiretroviral drugs. The staggering human toll of the AIDS pandemic has no historical precedent.

Ambitious preventive programmes based on public education, testing and counselling, and the distribution of condoms and clean needles have markedly reduced the spread of HIV in recent years. But such efforts alone cannot win the war against AIDS.

Victory in the struggle against AIDS calls for a vaccine.

There is now little scientific doubt that a safe and effective vaccine against HIV can be developed. Studies of non human primates and intensive research into the immunopathogenesis of HIV suggest that commercial production of a preventive vaccine for large scale use in human populations is a feasible goal.

Why has science taken so long to come to this consensus? Why has no candidate vaccine ever completed a phase III trial after nearly two decades of scientific inquiry? Why does it seem unlikely that an effective, affordable, and accessible HIV vaccine will come to market in time for the 10 year deadline set by President Bill Clinton in May 1997?

In *Big Shot*, US journalist Patricia Thomas sets out to answers questions like these in an engaging narrative in which the stories of several leading HIV vaccine strategies and their all too human developers are woven together with a novelist's skill. Thanks to Thomas's tireless investigative work—including 175 lengthy interviews with key players in the world of AIDS vaccine development—readers come to know on a first-name basis a large and diverse cast of scientific personalities, from those inhabiting the lab benches of upstart biotech firms to those who walk the corridors of power in the US National Institutes of Health.

While each character plays a vital part in the unfolding drama, Thomas leaves little doubt about who are the heroes and who are the villains. But fortunately her depictions of these gifted and complex individuals are never simplistic and usually include a few shades of grey.

When Thomas began work on her book in 1997, she expected to find that the technical challenges thrown up by the virus itself were largely to blame for the slow development of an AIDS vaccine. What she soon found, and brilliantly portrays in her book, is that progress on vaccine development has been derailed much more by political timidity, by anxieties about corporate profits and liabilities, and by petty rivalries between the theorists of academic science and the empiricists of applied research.

Ultimately, *Big Shot* shows that development of a safe and effective AIDS vaccine has failed because of the absence of an outspoken public constituency pushing for it. Drug companies have preferred making pills to be taken daily over vaccines taken only once. Likewise, AIDS activists have focused their attention on getting care for those already infected.

As Thomas points out, there have been no crowds of healthy people marching on Washington, demanding that science find a way to protect them from acquiring AIDS. Perhaps only when that happens will we get a usable vaccine and bring an end to AIDS for all time.

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WEBSITE OF THE WEEK

Interactive patient simulators When it comes to diagnosing and treating arrhythmias (p 719) and other potentially life threatening conditions, many doctors feel uneasy. You need lots of training and experience to feel confident in this area. The web lends itself to interactive skills assessment and learning.

Imagine you are making your hospital ward round and a patient collapses right in front of you. What would you do? Actually, basic and advanced life support is not difficult as long as you know what to do. But do you? If not, try the advanced cardiac life support simulator on www.acls.net. The program is simple, well done, and very, very stubborn when it comes to the sequence of actions; those who believe in the arts of medicine will be bitterly disappointed. This site also presents essential advanced cardiac life support algorithms and mnemonics that every doctor should know. It is true that a doctor's lifetime risk of observing a cardiac arrest is not high, but occasionally it happens and occasionally there is advanced life support equipment at hand. Who knows, one day even public access defibrillation may become reality on a large scale.

The internet also offers useful simulators for those who prefer to stick to basic life support measures (www.lessstress.com/cprintro.htm). The BBC, always a useful source, also has an interactive cardiopulmonary resuscitation test (www.bbc.co.uk/health/first_aid_action/hs_child/hs_resus.shtml). It is neatly done but unfortunately there is no provision for calling the ambulance or any help—a grave omission. If you want to direct lay people to a website for basic CPR training I would recommend depts.washington.edu/learncpr, which is supported by the University of Washington School of Medicine.

At www.trauma.org, under "moulage," there are several good simulations relating to the treatment of traumatic injuries. Just a warning: the virtual commentators, nurses, and medical students will treat you with little respect if you don't take the right measures—thank God I am not a traumatologist.

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Hit parade bmj.com

These articles scored the most hits on the *BMJ*'s website in the week of publication

FEBRUARY

1 **ABC of clinical electrocardiography: Introduction. I—Leads, rate, rhythm, and cardiac axis**
2002;324:415-8
6164 hits

2 **Editorial: Was it a heart attack?**
2002;324:377-8
5339 hits

3 **News: Advocates of PSA testing campaign to silence critics**
2002;324:255
5181 hits

4 **Recent developments: Breast cancer**
2002;324:410-4
4967 hits

5 **ABC of clinical electrocardiography: Introduction. II—Basic terminology**
2002;324 470-3
4792 hits

6 **Regular review: Peripheral neuropathy**
2002;324:466-9
4747 hits

7 **10-minute consultation: Rhinitis**
2002;324:403
3845 hits

8 **Editorial: Guidelines for managing community acquired pneumonia in adults**
2002;324:436-7
3802 hits

9 **News: US panel finds insufficient evidence to support mammography**
2002;324:255
3526 hits

10 **News extra: People who sleep for seven hours a night live longest**
2002;324:446
3414 hits

The Anatomists

Channel 4, 12 to 26 March, times vary

Rating: ★★★

The study of anatomy is a core component of the education of all medical undergraduates. The United Kingdom's Anatomy Acts regulate the conditions for this important study to ensure that the cadavers are dissected within licensed premises and that licensed teachers carry out supervision and teaching.

But how many of these medical students know anything about the reasons for this regulation or even, for that matter, anything about the history of anatomy, the focus of this series of three programmes?

The subject of dissection has for long been seen as a taboo, condemned by society with the backing of religious edict. It is little wonder, therefore, that the early attempts to gain insight into the structure of the human body were carried out in a cloak and dagger manner.

In this series, the surgeons, barbers, physicians, and artists of the past come alive in fascinating, if at times rather gory, scenes of the barbarities and other activities of anatomists seeking to further their knowledge. The Greeks Herophilus and Erasistratus in Egypt dissected the living and were the first to investigate the body's anatomy, but it was the activities of Galen in Rome in AD129 and Vesalius, during the renaissance, that set anatomy on a truly scientific footing. Both wrote extensively but also used public display to enhance their reputation. The series uses clinical anatomist and retired surgeon Harold Ellis to demonstrate how these historical figures practised their art. What is interesting is that, in using their superb craftsmanship to reproduce the structures of the body, Vesalius, da Vinci, and others bridged the gap between biological fact and art. Whether public dissections of criminals by Vesalius in the magnificent dissecting lecture theatre in Padua did the quest for knowledge any favours is another matter, especially as the identity of the individuals he dissected is now known.

The criminal activities of body snatchers such as Burke and Hare and the anatomist Knox are important chapters in our social history and serve to remind us of the undercover world of body dissection and trade in body parts. They also remind us of the need for regulation to control the acquisition of bodies for dissection. The details of these activities do not make for pleasant viewing and the programme makers certainly have used a considerable amount of realistic blood to make their points.

However, without this trade and its social context, the discovery of circulation by Harvey, a physician, and the works of Henry Gray might not have taken their rightful place in medical history. Here, the contributions of the late Roy Porter and Ruth Richardson to the narrative give the series a voice of authority. (Those wishing to know more would do well to read *Death, Dissection and the Destitute* by Ruth Richardson, Phoenix Press, 2001.) The programmes also cover contemporary anatomy, giving us a glimpse of teaching at the Royal College of Surgeons in London.

This series coincides with the London opening of Körperwelten or Body Worlds, Gunther von Hagens's controversial exhibition of plastinised bodies. The programmes introduce von Hagens, who maintains that he is an artist and thus is the latest individual to claim a connection between art and the science of the structure of the human body. Whether this particular exhibition is in good taste is another matter (*BMJ* 2001;323:698), but von Hagens appears as the contemporary equivalent of Vesalius, with the sensationalism of public displays of body parts once again attracting the crowds. This particular exhibition is nothing new as the public have always been able to view dissected cadavers, such as in Paris in the Musée Fragonard or in the former anatomy museums in cities such as Liverpool.

A point of concern is the introduction into the history of anatomy of the role of the pathologist and the storage of body parts. While one cannot condone the kind of activities that went on at Alder Hey Hospital in Liverpool, to infer that this is in a way related to the body snatchers of the past is unfortunate.

However, I recommend this series as an introduction to the story of the science of anatomy, albeit a rather gruesome and at times sensational one. I hope that it will go some way towards increasing public awareness of the history of what should still be seen as a core subject in medical education while at the same time removing some of the veils from the mysteries of the body.

CHANNEL 4/THE WELLCOME LIBRARY

Lateral view of a human skeleton, based on a woodcut by Vesalius

WINDFALL FILMS/CHANNEL 4

The Gunther von Hagens of the renaissance: Vesalius's public dissections turned anatomy into a stage production

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PERSONAL VIEW

Pilgrimage medicine

Even as I observed this congregation of 5000 pilgrims at 4300 metres, ready to pray to the great Vedic deity Shiva at a magnificent mountain lakeside in Gosainkunda, Nepal, I knew that many were in no mood to pray. They were stricken with altitude sickness in its various forms—acute mountain sickness, high altitude pulmonary oedema, and high altitude cerebral oedema.

Acute mountain sickness, which is just like having a hangover, can be relatively benign (with a headache, some nausea, and tiredness), but high altitude pulmonary oedema and high altitude cerebral oedema are undoubtedly life threatening. The initial symptoms of acute mountain sickness are warning signs to be heeded carefully. Alas, many pilgrims climb too high too fast (from Kathmandu at 1300 metres to the lake in two nights) and totally disregard initial symptoms.

Just like many impatient tourists that come to trek in the foothills of the great Himalayas, these pilgrims too are a determined bunch and do not turn back even in the face of increasing symptoms. Many claim that once you undertake the pilgrimage it does not bode well for your spiritual welfare to give it up halfway.

Recent studies have shown that acute mountain sickness is rampant in this population of pilgrims to Gosainkunda and that many pilgrims are dehydrated because they are fasting. Many are so serious about the fasting that they do not even drink water. Women are more meticulous about fasting and sometimes they present with severe dehydration.

Many pilgrims still feel that the sickness they experience is caused by the scent of the flowers and alpine vegetation that grow on the wayside. This is akin to what many Catholic fathers thought in the early 18th century when they were crossing these Himalayan mountain passes. Indeed Spanish Jesuit fathers in South America were the first in Western literature to document the symptoms of altitude sickness. The scent of the flowers as the cause of altitude sickness does not make sense, as I am fond of reminding the pilgrims, because invariably the patients improve significantly on descent, even though the flowers are still giving off their scent.

We have tried to encourage the Nepali government to campaign to increase awareness of altitude sickness among pilgrims. This has happened to some extent, but thank God for dexamethasone, a well established treatment for high altitude cerebral oedema. Many healthcare professionals who have helped out at the Gosainkunda Lake can clearly testify to the usefulness of steroids.

One study postulated that the visions that these high altitude pilgrims often report may not actually be divine revelations but just hallucinations caused by the cerebral oedema. The pilgrim community may not favour this rather scientific explanation.

Gosainkunda is just one high altitude sacred place to which people trek. There are many such holy sites scattered in the Himalayas. Damodar Kunda, Dudh Kunda, Lake Tilicho, Kedarnath, Badrinath, Muktinath—these are some other examples. Finally, because of the immensely increasing fascination that Buddhism holds for people, many pilgrims, including vast numbers of Westerners, visit Lhasa (3600 metres), Tibet, the cradle of Buddhism. Many experience the ill effects of altitude. This is because there is no chance for people to acclimatise as they make their journey quickly by air or by road. Acetazolamide taken after consultation with their doctors could be a useful precautionary measure to ward off the ill effects of sudden hypoxia in Lhasa.

Many pilgrims feel that the sickness they experience is caused by the scent of flowers

Pilgrims face other problems besides altitude. I have seen obese men and women, who can barely climb up stairs in their homes, undertaking high altitude pilgrimages on helicopter and horseback. Usually they decide to do this on the spur of the moment as a famous "guru" is going to lead them. The main problem is that you have to get down from the horse during the descent when the trail gets very steep, and your knees and hips may not be up to this. The pilgrimage then turns out to be a nightmare.

To get to many of these high altitude sites you may first have to go through cities such as Delhi or Calcutta where malaria lurks. Depending on the destination, it may be useful for pilgrim travellers to consider malaria prophylaxis and immunisation against diseases such as typhoid and hepatitis.

For pilgrims going to Mecca for the Haj, meningococcal vaccination would be particularly useful. The value of this was tragically demonstrated when some British citizens succumbed to meningitis on their return home from Mecca.

Pilgrimage medicine needs to be incorporated into the broader framework of travel medicine to ensure that pilgrims are aware of problems and diseases. Healthcare professionals can then effectively advise potential pilgrims depending on their destination and needs.

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SOUNDINGS

Imaginary conversations

We did not think much of most of our chiefs, our attending physicians at the hospital. We thought they were boring, irritating, old. "Would you like to end up like him?" asked one of my fellow residents one day, as we trudged behind the old man on ward rounds that seemed interminable on hot afternoons, when the beach offered a much more attractive alternative. "Most certainly not," I replied, with absolutely no doubt in my mind.

Sometimes we would change the treatments they ordered. We knew better. We would even hide patients from them on rounds, claiming that they were down having *x* rays, or drawing the curtains around their beds and claiming that they were indelicately indisposed. We also made up stories about our chiefs. Not real ones, but imaginary stories about made up situations that would illustrate some trait or characteristic of their personality or conduct.

There was the academic chief, very learned, always ready to quote a couple of references, but somehow always leaving you without a definite answer to what you wanted to know. "Is it true that when it rains there is a lot of water coming down from the sky?" "Well," he would answer in this imaginary conversation, "there is actually very little data on this subject. There is an old paper in the French literature, but small numbers, poorly documented, largely anecdotal."

More practical but obsessive to the extreme was another chief, a man of great achievements. "We saved this man's life as we picked him up from the sidewalk, sir. He had jumped from a five storey building—we stopped the bleeding, restored his airway, treated his pneumothorax, his ruptured viscera, his haemoperitoneum, his sepsis, his coagulopathy, his acute renal failure, his pulmonary oedema, his compartmental syndrome. He is now recovering, is afebrile, and off the respirator and off dialysis, but he is still not eating well, sir."

The reply in this particular imaginary conversation might have been: "What do you mean he is not eating? Did you speak to the patient to ask him what he would like to eat? Did you consider liquid supplements, butter balls, syrup? You had better consult the dietitian right away."

There are other stories, many that we do not know and will never know. For now the students and residents make them up about us.

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